State of California - Health and Human Services Agency

California Department of Public Health
Office of AIDS
HIV/AIDS Surveillance Program

ADULT HIV/AIDS CONFIDENTIAL CASE REPORT
(Patients ≥ 13 years of age at time of diagnosis)

I. This is for Health Department use. Uniquely identifying information is not transmitted to the Centers for Disease Control and Prevention.

Patient's name (last, first, MI) | Telephone number ( ) | Social Security Number

Address (number, street) | City | County | State | ZIP code

Date form completed (Month Day Year) | Report status: 1 New, 2 Update

II. *Health Department Use Only*

Report source | Reporting health department | State patient number | City/county patient number

Soundex code | Date of birth (Month Day Year) | Gender: 1 M, 2 F, 3 M►F, 4 F►M | CLIA number | Lab report/Accession number | *Confidential C&T number

*Publicly funded confidential counseling and testing sites only

III. Demographic Information

Diagnosis status at report (check one): 1 HIV Infection (not AIDS)..... 2 AIDS..... | Age at Diagnosis Years | Current status: 1 Alive, 2 Dead, 9 Unknown | Date of death (Month Day Year) | State/Territory of death | Country of birth: 1 U.S., 7 U.S. Territories (including Puerto Rico), 8 Other (specify):_____, 9 Unknown

ETHNICITY: 1 Hispanic, 2 Not Hispanic nor Latino

RACE: ☐ American Indian/Alaskan Native ☐ Black or African American ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Unknown

Expanded race (specify):_____

☐ Check if HIV infection is presumed to have been acquired outside United States and Territories. Specify country:_____

Residence at first diagnosis of HIV or AIDS: ☐ Homeless (Must use city/county/ZIP code of local health department (LHD) or facility of diagnosis.)

City | County | State/Country | ZIP code

IV. Facility of Diagnosis

Facility name | City | State/Country

Facility setting (check one): 1 Public, 2 Private, 3 Federal, 9 Unknown

Facility type (check one): 01 Physician, HMO; 22 Counseling and Testing Site; 29 Community Health Center; 30 Correctional Facility; 31 Hospital, inpatient; 32 Hospital, outpatient; 88 Other (specify):_____; 99 Unknown

V. Patient Risk History (Check all that apply.)

	Yes	No	Unknown
• Sex with a male	1	0	9
• Sex with a female	1	0	9
• Injected nonprescription drugs	1	0	9
• HETEROSEXUAL relations with any of the following:			
• Intravenous/injection drug user	1	0	9
• Bisexual male	1	0	9
• Person with hemophilia/coagulation disorder	1	0	9
• Transfusion recipient with documented HIV infection	1	0	9
• Transplant recipient with documented HIV infection	1	0	9
• Person with AIDS or documented HIV infection, risk not specified	1	0	9
• Received clotting factor for hemophilia/coagulation disorder	1	0	9

Specify disorder: 1 Factor VIII (Hemophilia A) 2 Factor IX (Hemophilia B) 8 Other (specify):_____

	Yes	No	Unknown
• Received transfusion of blood/components (other than clotting factor) First: (Month Year) Last: (Month Year)	1	0	9
• Received transplant of tissue/organs or artificial insemination.	1	0	9
• Worked in a health care or clinical laboratory setting..... (Specify occupation):_____	1	0	9
• Perinatally-acquired HIV infection regardless of year of birth...	1	0	9
• Other (specify)_____	1	0	9

VI. Laboratory Data (Indicate first documented test(s).)

A. HIV Antibody Test at Initial HIV/AIDS Diagnosis (Month Day Year)

- HIV-1 EIA.....
- HIV-1/HIV-2 combination EIA.....
- Rapid HIV-1 EIA.....
- HIV-1 Western Blot/IFA.....
- Other HIV antibody test..... (Specify):_____

B. *Positive* HIV Detection Test *(Record earliest test.)* (Month Day Year)

☐ Culture ☐ Antigen ☐ DNA PCR ☐ RNA PCR

☐ Other (specify):_____

Date of last documented ***negative*** HIV test..... (Month Day Year)

Specify type:_____

Specify facility type (use codes in Section IV):

01 22 29 30 31 32 99 88 (Specify):_____

If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician? Yes 1 | No 0 | Unknown 9

If yes, provide date of documentation by physician..... (Month Day Year)

C. HIV Viral Load Test *(Record earliest test.)* (Month Day Year)

Test type*: Version*:

Other (specify type and version):_____

Test result *(Record in copies/mL **and** log_{10} values.)*

☐ Detectable Copies/mL: , , Log_{10}: . Greater than: , , copies/mL

☐ Undetectable Less than: copies/mL

* Test type and version: 11 = NucliSens® HIV-1 QT (Organon-NASBA); 12 = Amplicor HIV-1 Monitor® (Roche-RT-PCR), version: 1.0 or 1.5; 13 = Bayer/Chiron (bDNA), version: 2.0 or 3.0; 18 = Other (kit name/manufacturer/version)_____

D. Immunologic Lab Tests - At or closest to current diagnostic status

- CD4 count..... , cells/µl
- CD4 percent..... %

(Month Day Year)

First <200 µl or <14%

- CD4 count..... , cells/µl
- CD4 percent..... %

(Month Day Year)

VII. Provider Information

Physician's name (last, first, MI)				Physician's telephone number ( )	Patient's/inmate's medical record number
Address (number, street)	City	State	ZIP code	Person completing form	Telephone number ( )

VIII. Clinical Status

Clinical record reviewed: Yes [1] No [0]

Enter date patient was diagnosed as:
- Asymptomatic (including acute retroviral syndrome and persistent generalized lymphadenopathy).....
- Symptomatic (not AIDS).....

Month / Day / Year

AIDS INDICATOR DISEASES	Initial Diagnosis Def.	Initial Diagnosis Pres.	Initial Date Month	Initial Date Year
Candidiasis, bronchi, trachea, or lungs	1	NA		
Candidiasis, esophageal	1	2		
Carcinoma, invasive cervical	1	NA		
Coccidioidomycosis, disseminated or extrapulmonary	1	NA		
Cryptococcosis, extrapulmonary	1	NA		
Cryptosporidiosis, chronic intestinal (>1 month duration)	1	NA		
Cytomegalovirus disease (other than in liver, spleen, or nodes)	1	NA		
Cytomegalovirus retinitis (with loss of vision)	1	2		
HIV encephalopathy	1	NA		
Herpes simplex: chronic ulcer(s) (>1 month duration): or bronchitis, pneumonitis, or esophagitis	1	NA		
Histoplasmosis, disseminated or extrapulmonary	1	NA		
Isosporiasis, chronic intestinal (>1 month duration)	1	NA		
Kaposi's sarcoma	1	2		

AIDS INDICATOR DISEASES	Initial Diagnosis Def.	Initial Diagnosis Pres.	Initial Date Month	Initial Date Year
Lymphoma, Burkitt's (or equivalent term)	1	NA		
Lymphoma, immunoblastic (or equivalent term)	1	NA		
Lymphoma, primary in brain	1	NA		
Mycobacterium avium complex or *M.kansasii*, disseminated or extrapulmonary	1	2		
M. tuberculosis, pulmonary*	1	2		
M. tuberculosis, disseminated or extrapulmonary*	1	2		
Mycobacterium of other species or unidentified species, disseminated or extrapulmonary	1	2		
Pneumocystis jiroveci pneumonia (PCP)	1	2		
Pneumonia, recurrent, in 12-month period	1	2		
Progressive multifocal leukoencephalopathy	1	NA		
Salmonella septicemia, recurrent	1	NA		
Toxoplasmosis of brain	1	2		
Wasting syndrome due to HIV	1	NA		

Def. = definitive diagnosis *Pres. = presumptive diagnosis*

* RVCT case number:

If HIV tests were not positive or were not done, does this patient have an immunodeficiency that would disqualify him/her from the AIDS case definition? Yes [1] No [0] Unknown [9]

IX. Treatment/Services Referrals

	Yes	No	Unknown
Has the patient been informed of his/her HIV infection?.....	1	0	9

This patient's partner(s) has been or will be notified about their HIV exposure and counseled by:

[1] Health Department [2] Physician/Provider [3] Patient [9] Unknown

This patient is receiving or has been referred for:	Yes	No	NA	Unknown
• HIV-related medical services.....	1	0	-	9
• Substance abuse treatment services.....	1	0	8	9

This patient received or is receiving:	Yes	No	Unknown
• Antiretroviral therapy.....	1	0	9
• PCP prophylaxis.....	1	0	9

This patient has been enrolled at:

Clinical Trial	*Clinic*
[1] NIH-sponsored	[1] HRSA-sponsored
[2] Other	[2] Other
[3] None	[3] None
[9] Unknown	[9] Unknown

This patient's medical treatment is primarily reimbursed by:

[1] Medicaid [2] Private insurance/HMO
[3] No coverage [4] Other public funding
[7] Clinical trial/government program [9] Unknown

For women:

	Yes	No	Unknown
• This patient is receiving or has been referred for gynecological or obstetrical services.....	1	0	9
• This patient is currently pregnant.....	1	0	9
• This patient has delivered live born infant(s).....	1	0	9

(If yes, provide birth information below for the most recent birth.)

Child's date of birth Month Day Year	Hospital of birth / City	State	Child's Soundex	***Health Department Use Only*** Child's state patient number

X. Comments

MAIL COMPLETED FORM MARKED "CONFIDENTIAL" TO THE HIV/AIDS SURVEILLANCE PROGRAM AT YOUR LOCAL HEALTH DEPARTMENT.
LHD contact information is available on the website: www.cdph.ca.gov/AIDS